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ABSTRACT

This report responds to Minnesota state legislative requirements for an annual summary report on the implementation of the Medical Education and Research Costs (MERC) Trust Fund. The report provides information on 1998 Trust Fund distribution and the status of applications and distributions for fiscal year 1999. It also includes information on the work of the MERC Advisory Committee and subcommittees, the medical education and research studies directed by the 1998 statute, and ongoing issues and concerns regarding the financing of medical education and research in Minnesota. Following an introductory chapter, individual chapters examine: (1) the MERC Trust fund (background information, the 1998 and 1999 trust funds, the general fund and federal match portions, and the Prepaid Medical Assistance Program (PMAP) and Prepaid General Assistance Medical Care (PGAMC)portions; (2) the MERC advisory committee (the Research subcommittee and the PMAP subcommittee); (3) medical education and research studies (review of eligible provider groups, the PMAP/PGAMC medical education distribution formula, and the trainee retention rate); and (5) ongoing issues and concerns (financing of medical education in a changing political and economic environment, and examination of the needs of the health professional workforce). Six appendices provide cost data, legislative text, and a list of advisory committee members (DB)

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Medical Education and Research Costs (MERC)

Annual Report on Program Implementation

March 1999

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Medical Education and Research Costs (MERC)

Annual Report on Program Implementation

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Purpose

This report was prepared pursuant to Minnesota Statute section 62J.69, which directs the Commissioner of Health to provide the Legislature with an annual summary report on the implementation of the Medical Education and Research Costs (MERC) Trust Fund. This report provides information on the 1998 Trust Fund distribution and the status of the application and distribution process for the current year, state fiscal year 1999. This report also includes information on the work of the MERC Advisory Committee and subcommittees, the medical education and research studies directed by the 1998 statute, and ongoing issues and concerns regarding the financing of medical education and research in Minnesota.

Background Information

Medical education and research are vital activities affecting not only the health care community, but the health of every citizen and the economy of the entire state. Health care is the state's leading industry, employing over 200,000 Minnesotans and generating at least $16 billion of the annual gross state product. The state's medical education and research infrastructure significantly influences Minnesota's health care system and overall economy.

The Minnesota Legislature recognizes the importance of medical education and research to the state and its economy. As part of the 1993 and 1994 MinnesotaCare Acts, legislators directed the Commissioner of Health to study the costs and financing of medical education and research. A MERC Advisory Task Force was created in 1993, and the Department has issued annual reports documenting the issues faced by medical education programs and teaching hospitals in the competitive health care market.

In 1996, the Minnesota Legislature established the Medical Education and Research Costs (MERC) Trust Fund to fund a portion of the costs of the clinical training of selected medical professionals (medical students and residents, dental students and residents, advanced practice nurses, physician assistants and PharmD students and residents). Teaching institutions have traditionally covered a portion of these costs by setting patient charges above what they would be in a non-teaching environment. As competition increases, however, health plans are increasingly unwilling to pay this teaching "increment," leaving teaching institutions at a competitive disadvantage. With a shift away from inpatient care, and cuts to Medicare funding of medical education, teaching institutions are finding it more and more difficult to fund the costs of clinical training.

The MERC Trust Fund

The Medical Education and Research Costs (MERC) Trust Fund was created in1996 by the Minnesota Legislature and funded for the first time by the 1997 Legislature. Applications for

funding from the MERC Trust Fund are submitted by sponsoring institutions, organizations that are organizationally and/or financially responsible for one or more teaching programs. Funds from the Trust Fund are disbursed to the sponsoring institutions, with explicit requirements to pass the funds through to the sites where clinical training occurs. Many entities in Minnesota are both sponsoring institutions and training sites, and many hospitals and clinics are training sites for several different teaching programs.

The MERC statute requires each sponsoring institution to submit the following data for each teaching program they are responsible for that wishes to obtain MERC funding: costs of clinical training, revenues associated with medical education, information on accreditation, information on the training sites used by the teaching program, and the number of full time equivalent (FTE) students or residents trained at each training site. The table below lists the sponsoring institutions who applied on behalf of training sites during the 1998 and 1999 MERC Trust Fund application process.

MERC 1998 and 1999 Trust Fund Applications

SPONSORING INSTITUTION	CITY	1998 TEACHING PROGRAMS	1999 TEACHING PROGRAMS
Abbott Northwestern Hospital	**Minneapolis**	2	2
Allina Health System/United Hospital	**Minneapolis**	1	1
Augsburg College	**Minneapolis**	1	1
College of St. Catherine	**St. Paul**	1	1
College of St. Scholastica	**Duluth**	2	2
Duluth Medical Education Council, Inc.	**Duluth**	1	1
Hennepin County Medical Center	**Minneapolis**	11	9
Mankato State University School of Nursing	**Mankato**	1	1
Mayo Foundation	**Rochester**	64	65
Minneapolis Sports Medicine Center	**Minneapolis**	1	1
Regions Hospital	**St. Paul**	6	6
St. Mary's Hospital U of MN	**Minneapolis**	1	1
United Hospital and Children's Healthcare	**St. Paul**	2	2
University of MN Academic Health Center	**Minneapolis**	57	62
Winona State University	**Winona**	2	2
Women's Health Care Nurse Practitioner Program	**St. Paul**	1	1
TOTAL		***154***	***158***

The 1998 MERC Trust Fund Distribution

The 1997 Minnesota Legislature allocated $5 million from the General Fund and $3.5 million from the Health Care Access Fund to the Medical Education and Research Costs (MERC) Trust Fund for distribution in 1998. These dollars were matched through federal Medicaid financial participation, for a total of approximately $17.8 million. The first Trust Fund distribution was completed in early 1998 to 16 sponsoring institutions on behalf of 154 teaching programs and more than 300 training sites. (Appendix 1 shows detailed information on the 1998 funding distribution from the MERC Trust Fund.) The 1998 MERC Trust Fund was distributed based on a formula which reflected the number of eligible trainee FTEs at a particular site as well as the statewide average cost of clinical training for that provider type. The Trust Fund reimbursed a uniform percentage of clinical training costs for each of the eight provider types. For the 1998 Trust Fund, this percentage was 5.9%. The annual average clinical training costs per trainee varied significantly across the eight provider types, as shown by the table below.

1998 MERC Distribution By Provider Type

Provider Type	Teaching Programs	Eligible FTEs	Average Cost Per Trainee	Adjusted Total Costs	% of Trust Fund	Grant Amount	Grant per Trainee	% of Costs Covered
Adv. Prac. Nurses	11	165.1	$20,537	$3,390,043	1.1255%	$199,899	$1,211	5.90%
Dental Students	1	107.2	$105,788	$11,341,531	3.7656%	$668,771	$6,238	5.90%
Dental Residents	12	76.0	$136,052	$10,345,394	3.4348%	$610,032	$8,023	5.90%
Medical Students	5	513.3	$23,489	$12,056,977	4.0031%	$710,958	$1,385	5.90%
Medical Residents	117	1,783.6	$146,765	$261,771,874	86.9125%	$15,435,778	$8,654	5.90%
PharmD Student	1	28.9	$22,093	$638,488	0.2120%	$37,649	$1,303	5.90%
PharmD Resident	6	16.3	$60,796	$987,935	0.3280%	$58,255	$3,585	5.90%
Physician Assistant	1	20.4	$32,287	$657,848	0.2184%	$38,791	$1,904	5.90%
Total	154	2,710.8	$111,109	$301,190,089	100.0000%	$17,760,133	$6,552	5.90%

The 1999 MERC Trust Fund

The 1998 Legislature established ongoing base funding for the MERC Trust Fund through a $10 million appropriation for FY 1999 and a $5 million annual base appropriation starting FY 2000. In addition, the Legislature finalized the formula for the distribution of medical education funds removed from the calculation of PMAP and PGAMC capitation rates, authorized by the 1997 Legislature. Therefore, the 1999 MERC Trust Fund consists of two potential funding sources: the General Fund appropriation with its federal match, and accumulated funds transferred from the Prepaid Medical Assistance Program (PMAP) and the Prepaid General Assistance Medical Care Program (PGAMC) capitation payments.

General Fund Appropriation Distribution

The General Fund appropriation for the 1999 MERC Trust Fund is $10 million, which will be matched with $10.6 million through federal Medicaid financial participation. The Minnesota Department of Human Services has indicated that this $20.6 million will likely be transferred to the Department of Health in May or June, and we anticipate distributing these funds in June of 1999 upon completion of the application process. Funds will be distributed using the same formula utilized to distribute last year's Trust Fund, covering a fixed percentage of the average clinical training costs for each provider type.

Although it appears that there will be a $10.6 million federal match on the 1999 General Fund appropriation of $10 million, it is unclear whether the Department of Human Services (DHS) will be able to obtain a federal match on future MERC Trust Fund appropriations. Reduced federal Disproportionate Share Hospital (DSH) payments, the Medicare "upper payment limit", and the medicaid charge limit interact to limit the ability of the state to continue to receiving federal matching funds on the General Fund Appropriation. The Department of Health will continue to work in partnership with the Minnesota Department of Human Services to attempt to obtain matching funds for MERC.

PMAP/PGMAC Fund Distribution

In the past, a portion of the public program payments to HMOs included an add-on to cover the incremental costs associated with medical education. It was assumed that HMOs were passing the education add-on to teaching institutions through their contracts with providers. The 1998 legislature approved removal of the medical education dollars currently included in the capitated rates of the Prepaid Medical Assistance Program (PMAP) and Prepaid General Assistance Medical Care (PGAMC). These medical education payments will be removed from health plan rates and will be transferred to the MERC Trust Fund, where they will be transferred directly to the programs and clinics that provide clinical training and serve PMAP, PGAMC, GA, and MA enrollees. This transfer of medical education dollars from PMAP and PGAMC to the MERC Trust Fund allows for a more direct and equitable payment of the public program educational dollars. It is important to note that these dollars from the public programs are not new dollars for medical education. Rather, they are existing medical education dollars that can be targeted more effectively by distribution through the MERC Trust Fund.

The Minnesota Department of Human Services has applied for a federal waiver to allow Prepaid Medical Assistance Program (PMAP) and Prepaid General Assistance Medical Care (PGAMC) medical education funds to be transferred from health plan capitation payments to the MERC Trust Fund for distribution. These medical education dollars will be transferred to the Trust Fund monthly beginning the first day of the month one full month after the waiver is approved. For example, if the waiver is approved on March 15th by the Health Care Financing Administration, the first monthly transfer will occur after May 1st and will consist of May

PMAP/PGAMC funds. In this hypothetical example, in state fiscal year 1999, the MERC Trust Fund will only receive PMAP and PGAMC funds from May and June 1999. The Department of Health would distribute these PMAP and PGAMC medical education funds that have been accumulated through June 30th to sponsoring institutions by August 30th. The timing of this distribution most likely would be separate from the General Fund Appropriation distribution.

Because of the uncertainty surrounding the receipt of the federal waiver, it is possible that no funds from the PMAP/PGAMC carve out will be available for the state fiscal year ending June 30,1999. For example, if approval of the federal waiver is received after May 31st, the Department of Human Services would begin removing medical education payments from capitation rates no sooner than July 1st, after the end of the state fiscal year ending June 30, 1999. Upon waiver approval, the Department of Health expects to be receiving monthly transfers of the PMAP/PGAMC carve out funds from DHS for fiscal year 2000. MDH intends to distribute these funds twice annually to sponsoring institutions. Any funds accumulated from July 1999 through December 1999 will likely be distributed in January of the year 2000, and funds accumulated from January through June of the year 2000 will likely be distributed in July 2000. All fiscal year 2000 (July 1999 through June 2000) distributions will be based on information received on the year 2000 MERC application. A similar process will be used for future years.

As specified in statute, the formula used to distribute the PMAP and PGAMC funds will equally weigh clinical training costs and public program volume. Information on total PMAP/PGAMC/GA/MA revenues collected on the MERC application form will be used to proxy public program volume.

MERC Advisory Committee

The MERC Advisory Committee and its chair are appointed by the Commissioner of Health to advise the Commissioner on issues impacting medical education and research in Minnesota.

In 1998, the Committee participated in a number of activities including the following:

- Provided valuable input to the Department of Health to aid in the development of the 1999 MERC application, and to make the application process as efficient as possible.
- Successfully worked with the Department of Health to accomplish the distribution of the first MERC Trust Fund grants to sponsoring institutions, and training sites around the State.
- Further defined the issues affecting medical education, especially the effects of the 1997 Balanced Budget Act, and the ensuing Medicare cuts.
- Through its Research Subcommittee, worked to identify the areas of medical research that are at-risk due to increased competition in the health care market.

- Through its PMAP subcommittee, worked to reach consensus on the distribution formula for the PMAP and PGAMC carve-out for fiscal year 1999.

- Began the process of identifying primary care issues in rural Minnesota as a first step towards developing a strategy for workforce planning.

Research Subcommittee

Under Minnesota Statute 62J.69, the MERC Advisory Committee shall continue to study and make recommendations on: (1) the funding of medical research consistent with work currently mandated by the legislature and under way at the Department of Health; and: (2) the costs and benefits associated with medical education and research. To satisfy this legislative requirement, the MERC Advisory Committee charged the Research Subcommittee to meet in November 1998 to examine the effect of reduced patient revenues on medical research, and the need to develop the research component of MERC.

The Research Subcommittee concluded the following:

- It is difficult, if not impossible, to track the amount of patient care revenue that has been used to fund medical research, particularly because teaching, research and patient care are performed in unison. Past efforts to quantify research costs were unsuccessful and the subcommittee did not recommend renewed efforts.

- There is a need to strengthen Minnesota's ability to draw talented young researchers. We should examine ways to fund preliminary research and data collection activities that help to pave the way for NIH grants for young researchers.

- There appears to be unanimous support for the statement that managed care has resulted in increased demands on physician's time with a corresponding decrease in physician's ability to conduct or participate in clinical research. Research facilities are finding it extremely difficult to fund clinical research and recruit top candidates for clinical research in the managed care environment.

- There is a need for more translational research, in which medical advances resulting from research are introduced into clinical practice.

- There is a need to fund more physician-based research projects, which are less likely to be funded by the National Institute of Health (NIH), and yet directly impact patient care.

- Private/public/non-profit collaboration is required in order to leverage resources for funding research in Minnesota. The role of industry, providers, managed care and

government needs to be defined. A collaboration is necessary to ensure adequate support for clinical research.

- Good research attracts patients to Minnesota, bringing patient care revenue to the state. The state also benefits from a manufacturing industry, which has grown as a result of medical research, thereby increasing employment and tax revenue.

As the funding available for medical education and research declines and the costs associated with medical education rise, it is important to ensure that the quality and quantity of medical research performed at Minnesota's teaching hospitals and clinics does not decline. The MERC Advisory Committee and the Department of Health should determine how medical research can most effectively and efficiently be funded in today's changing healthcare market, and what the State's role in funding medical research should be. It is important that the Department of Health examine these issues and begin to draw consensus on the role of the state in funding research and identifying funding mechanisms.

PMAP Subcommittee

The 1998 Legislature approved the distribution of medical education dollars that will be transferred from the Prepaid Medical Assistance Program (PMAP) and Prepaid General Assistance Medical Care Program (PGAMC) to the MERC Trust Fund. The percentage carve-out from the capitation rates, which averaged 4.4% of the rates, was based on previous payments to providers under fee-for-service. Carve-out percentages varied by region, and the average was made up of a weighted average of the following carve-out percentages of the rates: Hennepin 6.3%, Metro Area 2.0%, Other 1.6%. The amount carved out of health plan rates will depend on Medical Assistance inpatient hospital fee-for-service direct medical education costs and Medicare percentages for indirect costs. MDH will receive monthly distributions from DHS commencing the 1st of the month, one full month after waiver approval.

There have been concerns that:

- The 6.3% carve-out for Hennepin County was based on the assumption that 6.3% of both outpatient and inpatient funds had been going to medical education, when in fact, only the relatively smaller inpatient portion had a medical education component. Therefore the carve out, based on 6.3% of both inpatient and outpatient funds, would result in a disproportionately larger revenue reduction for Hennepin County.

- For the two largest hospitals, Regions Hospital and Hennepin County medical Center, public program revenue is a large part of their business. The carve out would result in their getting less public program revenue than under current payment rates.

- Because the pending waiver application to the Health Care Financing Administration makes the timing of the carve-out uncertain, this presents problems in strategic planning and in negotiations between hospitals and health plans.

Fee-for-service payments for medical education will not be part of MERC and will continue to remain direct payments to hospitals, and MinnesotaCare payments remain direct payments to health plans.

There have been concerns about the existing MERC PMAP/PGAMC distribution formula, which currently weights both education and public program volume equally. There is the view that the carve-out funds were Medical Assistance medical education dollars, and should be targeted entirely to medical education. The opposing view, however, stresses the fact that these are public program funds intended to support medical education only in organizations that serve PMAP and PGAMC patients; therefore; the public program volume factor should receive greater weight than the education factor. However, in the end, there was consensus that the current formula was appropriate for the 1999 MERC Trust Fund application and distribution. In addition, the committee agreed that the carve out be preserved since it is not implemented without approval through the federal waiver, and that the federal match as a component of the rates was desirable.

Medical Education and Research Studies

The 1998 Legislature, while providing ongoing support for the MERC Trust Fund, did not provide the Department of Health with administrative funding to administer the Trust Fund and complete the other projects required by the statute. The Department has administered the MERC Trust Fund with existing staff and has chosen to focus current resources on the timely and accurate distribution of the MERC Trust Fund. It is the Department's intention to complete other projects directed in the statute as time allows. The Department of Health recognizes the importance of these studies, but also wishes to stress that adequate administrative funding is crucial to allow each of the following issues to be examined throughly.

Review of Eligible Provider Groups

The Legislature gave the Commissioner of Health authority to review the provider groups eligible for the MERC Trust Fund (*Minnesota Statutes, Section 62J.69, Subdivision 5)* to assure that the distribution of funds is consistent with the purpose of the statute, which is to support medical education in patient care training sites that have experienced a loss of medical education funding due to increased competition in the health care market. The Department of Health is currently reviewing the financing of medical education for chiropractors to determine whether market forces have resulted in a loss of patient care dollars that were formerly available for chiropractic education. In performing this review, the Department of Health and the MERC Advisory Committee are to consider the degree to which the training of chiropractors:

(1) takes place in patient care settings which are consistent with the purpose of the MERC Trust Fund;

(2) is funded with patient care revenues;

(3) takes place in patient care settings which face increased financial pressure as a result of competition with non-teaching patient care entities, and

(4) emphasizes primary care or specialties which are in under supply in Minnesota.

Advisory Committee Structure and Composition

In addition, the Legislature directed the Department of Health to conduct a study of the structure and composition of the MERC Advisory Committee (1998 Minnesota Laws, Chapter 407, Article 2, Section 98). The Department is currently reviewing the structure and membership of the MERC Advisory Committee to determine whether it equitably represents all of the stakeholders in the health care industry, including consumers. The Commissioner of Health will appoint committee members in the coming months.

Examination of the PMAP/PGAMC Medical Education Distribution Formula

As directed by the Legislature, the Department of Health, with the assistance of the MERC Advisory Committee and its PMAP Subcommittee, has begun to examine the current statutory PMAP/PGAMC medical education distribution formula to determine whether adjustments are necessary to ensure the equitable and efficient distribution of these funds *(1998 Minnesota Laws, Chapter 407, Article 2, Section 98)*. Meetings of the PMAP Subcommittee have helped define the distribution formula issues. If any PMAP/PGAMC funds are available for distribution during state fiscal year 1999, they will be distributed according to the formula set in statute during the 1998 legislative session, which equally weighs public program volume and clinical training costs.

Additional Criteria for Consideration in the MERC Formula

Minnesota Trainee Retention Rate

The 1998 Legislature directed the Department of Health to study additional criteria for consideration in the MERC formula, including the criteria that the trainees practice medicine in Minnesota after graduation *(1998 Minnesota Laws, Chapter 407, Article 2, Section 98)*. The perception was that the sponsoring institutions in Minnesota would be able to determine the percentage of their graduates who currently practice medicine in Minnesota by analyzing the practice addresses and license status of their alumni. Many sponsoring institutions, however, do

not maintain records of alumni or have incomplete or inaccurate alumni data for several reasons. As physicians move, retire, or change occupation, they may not supply the sponsoring institution with updated information; thus, the data maintained by the sponsoring institution may not be accurate or complete, or necessarily consistent with the records of other institutions who utilize a different procedure to track alumni or have maintained records for differing time periods.

Since sponsoring institutions in Minnesota cannot determine the percentage of their graduates who currently practice medicine in Minnesota from the data they currently collect, the Department of Health asked the Minnesota Board of Medical Practice (BMP) to supply data to facilitate the calculation of the number of physicians currently practicing in Minnesota who attended each Minnesota sponsoring institution during an arbitrary time period utilized for data consistency (ten years). The sponsoring institutions were then asked how many physicians have completed their medical school or residency programs during the last ten years. One could then calculate the percentage of physicians currently licenced to practice medicine in Minnesota who graduated from each sponsoring institution by dividing the number of physicians currently practicing in Minnesota who graduated from each sponsoring institution during the last ten years by the number of physicians completing a program from that sponsoring institution during the same time period.

In the course of reviewing data from the BMP, however, the Department of Health discovered that it was of limited usefulness. The data from the BMP was largely incomplete. Out of about 4,700 physicians with practice addresses in Minnesota and licensed in the last ten years, 300 physicians did not identify their medical schools or location of residency program. Furthermore, half of the 4,700 physicians identified either their medical school or location of residency program, but not both. In most cases, it is impossible to tell whether a school is a medical school, a residency program location, or a sponsoring institution; or whether the physician graduated from the program or only attended the program for a short time. In addition, it is often impossible to tell which physicians graduated from Minnesota institutions because location addresses were not supplied and school names were indeterminate in many cases. Dates of program attendance or graduation were also not given for over 60 percent of the records, therefore license dates were used to proxy graduation dates. This resulted in inconsistency between BMP data and the data collected from sponsoring institutions to measure the number of graduates from each program in the last ten years.

Since the Minnesota Department of Health does not have knowledge of additional data sources at this time, it is impossible to determine with an acceptable degree of accuracy the percentage of physicians who remain in Minnesota after completing medical school and/or residency programs at Minnesota sponsoring institutions. Thus, it is not feasible at this time to include as criteria for the distribution of the Medical Education and Research Costs (MERC) Trust Fund the percentage of trainees who remain in Minnesota to practice medicine upon completion of medical school or a residency program. The Minnesota Department of Health, however, will continue exploring whether additional data sources or approaches are available to help address this issue.

Other Criteria for Consideration in the MERC Formula

The Department of Health recognizes the necessity of determining whether any additional criteria beyond the current statutory criteria should be utilized in weighting future distributions of the MERC Trust Fund, and plans to conduct further analysis in this area and to make this a priority for discussion in future MERC meetings. It is important that we consider the effects of the provider, specialty, and geographic distribution of the workforce of medical professionals on access to quality health care and the cost of healthcare for all Minnesotans. This may include not only providing incentives to programs which train medical professionals in shortage specialty areas, but also funding the education of professionals who will serve in Minnesota's under served geographic locations. In addition, there exists an increasingly problematic shortage of less specialized nurses, especially certified nursing assistants. Hospitals, clinics, and nursing homes often pay for the training of such employees, but due to financial constraints are unable to pay these providers high enough wages to retain them in a labor driven market. The extent to which the MERC Trust Fund dollars can be targeted to assist in alleviating workforce shortages should be examined.

Ongoing Issues and Concerns

The Department of Health should continue to identify the issues that affect the funding of graduate medical education, including the effects of the Balanced Budget Act of 1997.

A study conducted by the University of Minnesota indicates that the 33 percent reduction in Medicare Indirect Medical Education over the next five years set into motion by the Balanced Budget Act of 1997 will cost Minnesota's teaching institutions about $100 million over the next five years. In addition, an increasing amount of patient care dollars are being lost as the health care market becomes more competitive, putting greater financial strain on teaching institutions. Teaching programs in Minnesota have indicated that a medical doctor in a teaching institution must see 25 percent more patients to receive the same revenue he or she did two years ago. Unless such institutions receive additional funding, such medical doctors must either spend less time with each patient, which would reduce the quality of care given to these patients; spend less time with residents and students, reducing the quality of education these students and residents receive; or reduce the amount of medical research he or she is able to conduct.

While the revenues available for medical education are declining, the costs of medical education are increasing, due to the increase in knowledge today's medical professionals are required to obtain, and changes in the health care delivery system. To meet the needs of today's medical professionals, medical education programs need to incorporate several areas of study that were not as strongly emphasized or not issues years ago, such as preventive medicine, nutrition, alternative therapies, advanced scientific knowledge and the operation of medical devises,

managed care, information technology, and the business of health care. Such changes increase the costs of medical education. The costs of clinical training are increasing due to the move towards community based education necessitated by the change in Minnesota's health care delivery system. Clinical training is more expensive at smaller community training sites because such sites do not have the economies of scale that large training sites benefit from. It is important that medical education is adequately funded during these changing times to avoid an erosion in the quality of medical education received by tomorrow's health care professionals.

Continue to Examine the Needs of the Health Professional Workforce

In today's competitive health care market, teaching hospitals are increasingly unable to finance medical education and research because third party payers are unwilling to pay the higher costs associated with such activities. Without a stable funding source for medical education and research, teaching hospitals are forced to offer residencies in specialties that minimize their costs, which does not necessarily supply the speciality or geographic distribution of medical professionals optimal for Minnesota's population.

The Minnesota Department of Health therefore has concerns about the geographic distribution of providers, and whether there is an adequate supply of certain providers. It is the department's intention to analyze data from a variety of sources to further define workforce planning issues and how the MERC Trust Fund can be used to address any disparities.

Appendix 1

Medical Education and Research Costs (MERC)
1998 Trust Fund Distribution

The MERC Trust Fund was established in 1996 to provide funding for the clinical training of selected medical professions. The purpose of this funding is to compensate teaching facilities for a portion of the costs of clinical training provided in a patient care setting. These are costs that have traditionally been covered by teaching facilities charging higher rates for patient care, a strategy that is becoming more and more difficult as competition increases.

The MERC Trust Fund was established in 1996 and funded in 1997, with $5 million from the General Fund and $3.5 million from the Health Care Access Fund. In addition, $9.26 million in Federal matching funds have been approved by HCFA, bringing the total Trust Fund for 1998 distribution to $17.76 million.

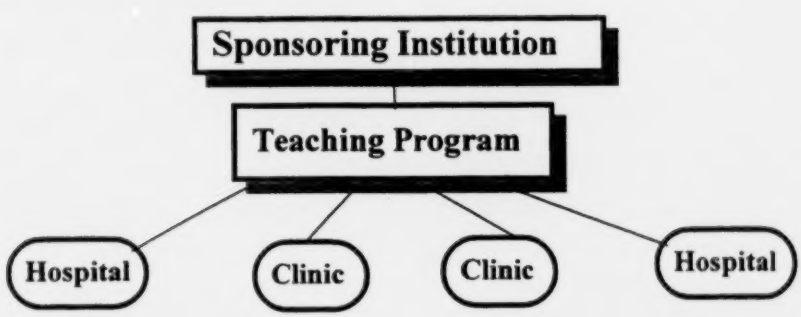
Provider Types included in the MERC Trust Fund

- Advanced Practice Nurses;
- Dental Students;
- Dental Residents;
- Medical Students;
- Medical Residents;
- PharmD Students;
- PharmD Residents;
- Physician Assistants.

$8,500,000 General/Access Fund
$9,260,133 Federal Match

$17,760,133 Total 1998 Trust Fund

Applications for the 1998 MERC Trust Fund were due in November, 1997. The Trust Fund received 16 applications on behalf of 154 teaching programs, representing over 300 sites of training and 2,710 trainees. Applications are submitted by ***Sponsoring Institutions,*** the organizations that are organizationally and/or financially responsible for one or more ***teaching programs.*** Funds will be disbursed to the sponsoring institutions, with explicit requirements to pass the funds through to the ***training sites*** where clinical training takes place. Many entities in Minnesota are both sponsoring institutions *and* training sites. Many hospitals and clinics are training sites for several different teaching programs.



The 1998 MERC Trust Fund is distributed based on a formula which reflects the number of eligible FTEs at a particular site as well as the statewide average cost of clinical training for that provider type. The Trust Fund reimburses a uniform percentage of clinical training costs for each of the 8 provider types. For the 1998 Trust Fund, this percentage is 5.9%. The annual average clinical training costs per trainee vary significantly across the 8 provider types (See table below, data from MERC applications, based on audited financial data from fiscal 1996.)

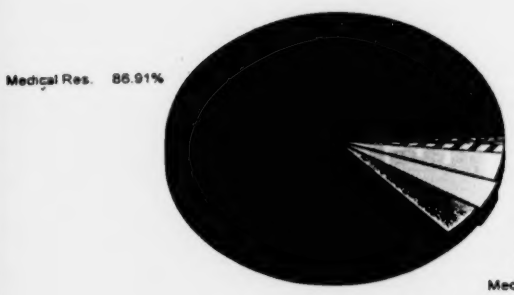
MERC Distribution by Provider Type

Provider Type	Number of Programs	Eligible FTEs	Average Cost Per Trainee*	Adjusted Total Costs**	% of Trust Fund	Grant Amount	Grant Per Trainee	% of Costs Covered
1:Adv.Pract. Nurses	11	165.0700	$20,537	$3,390,043	1.1255%	$199,899	$1,211	5.90%
2: Dental Students	1	107.2100	$105,788	$11,341,531	3.7656%	$668,771	$6,238	5.90%
3: Dental Residents	12	76.0400	$136,052	$10,345,394	3.4348%	$610,032	$8,023	5.90%
4: Medical Students	5	513.3031	$23,489	$12,056,977	4.0031%	$710,958	$1,385	5.90%
5:Medical Residents	117	1,783.6124	$146,765	$261,771,874	86.9125%	$15,435,778	$8,654	5.90%
6: PharmD Student	1	28.9000	$22,093	$638,488	0.2120%	$37,649	$1,303	5.90%
7: PharmD Resident	6	16.2500	$60,796	$987,935	0.3280%	$58,255	$3,585	5.90%
8:Physician Assistant	1	20.3750	$32,287	$657,848	0.2184%	$38,791	$1,904	5.90%
Total	154	2,710.7605	$111,109	$301,190,089	100.0000%	$17,760,133	$6,552	5.90%

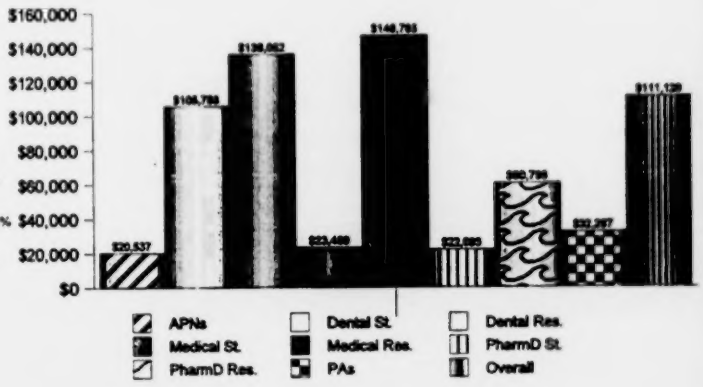
* Average Cost per trainee was calculated by taking the Total Clinical Costs for all programs of a particular provider type and dividing this total by the Total FTEs for that provider type.

** Adjusted Total Costs is calculated by taking the Average Cost per Trainee times the number of eligible FTEs.

Distribution of Trust Fund by Provider Type

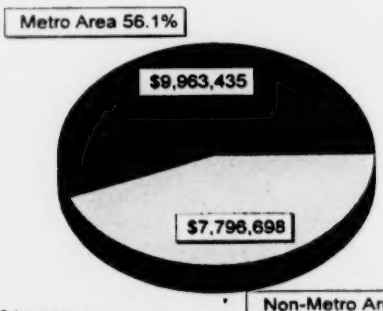


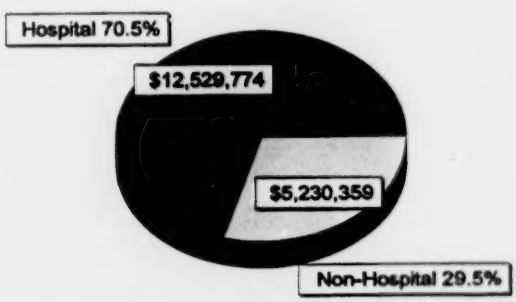
Average Cost for Clinical Training by Provider Type



Trust Fund Distribution

Setting





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Applications and Disbursements for the 1998 MERC Trust Fund

Applications to the 1998 Trust Fund			
Sponsoring Institution	**City**	**Teaching Programs**	**Eligible FTEs**
Abbott Northwestern Hospital	Minneapolis	2	32.0000
Allina Health System/United Hospital	Minneapolis	1	17.0300
Augsburg College	Minneapolis	1	20.3750
College of St. Catherine	St. Paul	1	13.2500
College of St. Scholastica	Duluth	2	15.3000
Duluth Medical Education Council, Inc.	Duluth	1	29.0000
Hennepin County Medical Center	Minneapolis	11	192.9100
Mankato State University School of Nursing	Mankato	1	15.9150
Mayo Foundation	Rochester	64	919.4284
Minneapolis Sports Medicine Center	Minneapolis	1	1.6000
Regions Hospital	St. Paul	6	62.8900
St. Mary's Hospital U of MN	Minneapolis	1	38.0000
United Hospital and Children's Healthcare	St. Paul	2	3.2500
University of MN Academic Health Center	Minneapolis	57	1,323.4871
Winona State University	Winona	2	18.3500
Women's HealthCare Nurse Practitioner Program	St. Paul	1	7.9750
TOTAL		**154**	**2,710.7605**

The above *sponsoring institutions* have applied on behalf of the *teaching programs* they administer and the *training sites* used by these teaching programs. As required by the MERC statute, the applications report for each teaching program: costs of clinical training, revenues associated with medical education, information on accreditation, and information on the training sites used by the teaching program, and the number of Full Time Equivalents (FTEs) trained at each training site. Funding from the MERC Trust Fund is directed to the Sponsoring Institutions, with specific requirements that these funds be forwarded to the actual training sites.

Applications are coordinated by, and funding directed to, the Sponsoring Institutions, rather than the training sites, to preserve the integrity of the teaching programs, and so that accurate and complete information about medical education teaching programs can be obtained.

The MERC Trust Fund dollars will flow from the Trust Fund through the Sponsoring Institutions to the training sites. The table below reports information on how much of the MERC Trust Fund will be received by the training sites used for medical education in Minnesota. As mentioned above, many of these hospitals and clinics are training sites for numerous teaching programs, and for this table, we have summed the grant amounts each site will receive from each of the teaching programs they participate in, so that their total revenue from MERC is reflected.

Appendix 1

MERC Trust Fund 1998

Clinical Training Sites

Training Site	City	Number of Eligible Trainees	Percent of Trust Fund	Grant Amount
St. Mary's Hospital	Rochester	384.69	16.86%	$2,994,574
Mayo Clinic	Rochester	370.27	16.27%	$2,890,271
Hennepin County Medical Center	Minneapolis	375.89	13.87%	$2,463,066
Fairview University Medical Center	Minneapolis	308.33	11.42%	$2,027,792
Regions Hospital	St. Paul	207.43	7.61%	$1,350,994
Rochester Methodist Hospital	Rochester	156.78	7.00%	$1,243,215
U of MN Dental School Clinic	Minneapolis	156.03	5.97%	$1,060,430
Fairview Riverside Hospital	Minneapolis	83.88	3.75%	$665,495
Abbott Northwestern Hospital	Minneapolis	74.90	2.12%	$376,657
North Memorial Medical Center	Robbinsdale	39.08	1.47%	$261,705
Children's Health Care St. Paul	St. Paul	43.21	1.40%	$248,168
U of MN Surgery	Minneapolis	22.00	1.07%	$190,393
St. Joseph's	St. Paul	19.63	0.87%	$155,344
Children's Health Care Minneapolis	Minneapolis	28.33	0.77%	$137,424
HealthSystem MN	St. Louis Park	14.88	0.73%	$128,775
Mayo Psychiatry & Psychology Treatment Center	Rochester	14.90	0.64%	$114,410
St. Luke's Hospital of Duluth	Duluth	14.06	0.61%	$109,000
United Hospital	St. Paul	13.14	0.60%	$106,113
St. Mary's Medical Center	Duluth	12.25	0.53%	$93,425
St. Johns Hospital HealthEast	Maplewood	11.01	0.41%	$73,476
University Affiliated Family Physicians	St. Paul	8.42	0.41%	$72,869
HealthPartners	Bloomington	19.92	0.40%	$70,185
Duluth Family Practice Center	Duluth	16.95	0.38%	$66,728
Methodist Hospital	St. Louis Park	13.34	0.37%	$66,096
Gillette Children's Hospital	St. Paul	6.65	0.27%	$47,200
Duluth Clinic	Duluth	32.37	0.25%	$44,500
Rural Physician Program	Minneapolis	23.00	0.18%	$31,856
Park Nicollet Clinic	Minneapolis	9.02	0.15%	$25,810
St. Cloud Hospital	St. Cloud	3.29	0.14%	$25,518
Community-University HealthCare Center	Bloomington	4.79	0.14%	$24,732
Mankato Clinic	Mankato	4.49	0.12%	$21,812
U of MN Lab and Pathology	Minneapolis	2.46	0.12%	$21,289
Park Nicollet Hand Center	St. Louis Park	2.00	0.10%	$17,308
Institute for Research and Education	Minneapolis	2.00	0.10%	$17,308
Family Practice Center	St. Cloud	1.88	0.09%	$15,466
Unity Hospital	Fridley	2.59	0.08%	$14,971
Waseca Area Medical Center	Waseca	1.93	0.08%	$13,431
Duluth Ob/Gyn Assoc.	Duluth	9.19	0.07%	$12,734
Colon and Rectal Surgery Assoc	St. Paul	1.19	0.06%	$10,299
Other Clinics- combined		163.68	2.20%	$391,518
Other Hospitals- combined		30.92	0.33%	$57,774
TOTAL		**2,710.76**	**100.00%**	**$17,760,133**

Appendix 2

Minnesota Department of Health
Medical Education and Research Costs (MERC)
Web Page Information

http://www.health.state.mn.us/divs/hpsc/hep/merc/merc.htm

The MERC Web Page was created for the 1998 MERC application process, and has been expanded and updated to include data about the MERC project, the MERC legislation, and the 1999 MERC application process. The web page also offers a means of electronic communication with the Health Economics Program staff and a method to order MERC reports or join the MERC mailing list. The following information outlines the resources available at the site.

Overview of MERC

(http://www.health.state.mn.us/divs/hpsc/hep/merc/geninfo.htm)

This page provides a brief description of key events and legislation in the history of the MERC project.

MERC 1998 Trust Fund Distribution

(http://www.health.state.mn.us/divs/hpsc/hep/merc/funddist.htm)

This page contains an overview of the process and outcomes of the 1998 Trust Fund distribution, including the costs of certain provider types and some demographic characteristics of the organizations who received MERC funds.

MERC Legislative Reports

(http://www.health.state.mn.us/divs/hpsc/hep/merc/mercrept.htm)

This page contain links to the executive summaries of these reports:

- **"MERC, A Final Report to the Legislature--February 1996"**
- **"MERC Study Recommendations and Progress Report to the Legislature--December 1996"**
- **"MERC Annual Report on Program Implementation and Recommendations--April 1998"**

and the full text of this report:

- **"Recommendations on Distribution of PMAP/PGMAC Funds"**

MERC Advisory Committee

(http://www.health.state.mn.us/divs/hpsc/hep/merc/adcomem.htm)

This page lists the members of the MERC Advisory Committee, a committee made up of representatives of health care providers, insurers, consumers and other stakeholders who advise the Department of Health about medical education and research costs. This page also has links to pages containing a schedule of MERC Advisory Committee meetings (which are open to the public) and minutes from recent Advisory Committee meetings.

Appendix 2

MERC Trust Fund Legislation

(http://www.health.state.mn.us/divs/hpsc/hep/merc/merclgpg.htm)

This page contains a summary of both the 1997 and the 1998 legislation that relate to the MERC Trust Fund and the MERC Project.

MERC Definitions

(http://www.health.state.mn.us/divs/hpsc/hep/merc/mercdefs.htm)

Many important terms and concepts referred to in the MERC legislation and the MERC application are defined here

1999 MERC Trust Fund Application

(http://www.health.state.mn.us/divs/hpsc/hep/merc/mcapinfo.htm)

This page has been developed to assist sponsoring institutions, teaching programs, and training sites as they complete the MERC application process. It contains:

- **An Overview of the Application and Distribution Process (formula and example of distribution method.)**
- **Frequently Asked Questions (about the application process)**
- **MERC Hospital Contact List: provided teaching programs and training sites with contact people at larger hospitals who have access to MA and GAMC volume information (for Question 9)**
- **MA Provider Number List**

This page will also provide a means for those who are completing the MERC application to contact the Health Economics Program staff who work on the MERC project.

For questions about MERC or the Health Economics Program, please contact the Minnesota Department of Health's Health Economics Program at 651-282-5601, by e-mail at hep@health.state.mn.us , or visit our web site at http://www.health.state.mn.us/divs/hpsc/hep/merc/merc.htm .

Appendix 3

1997 MERC Statute and Uncodified Session Laws

Minnesota Statute 62J.69: Medical Education and Research Trust Fund.

Subdivision 1. **Definitions.** For purposes of this section, the following definitions apply:

(a) "Medical education" means the accredited clinical training program of physicians (medical students and residents), doctor of pharmacy practitioners, dentists, advanced practice nurses (clinical nurse specialist, certified registered nurse anesthetists, nurse practitioners, and certified nurse midwives), and physician assistants.

(b) "Clinical training" means accredited training that is funded and was historically funded in part by inpatient care revenues and that occurs in both inpatient and ambulatory care settings.

(c) "Trainee" means students involved in an accredited clinical training program for medical education as defined in paragraph (a).

(d) "Health care research" means approved clinical, outcomes, and health services investigations that are funded by patient out-of-pocket expenses or a third-party payer.

(e) "Commissioner" means the commissioner of health.

(f) "Teaching institutions" means any hospital, medical center, clinic, or other organization that currently sponsors or conducts accredited medical education programs or clinical research in Minnesota.

Subd. 2. **Allocation and funding for medical education and research**(a) The commissioner may establish a trust fund for the purposes of funding medical education and research activities in the state of Minnesota.

(b) By January 1, 1997, the commissioner may appoint an advisory committee to provide advice and oversight on the distribution of funds from the medical education and research trust fund. If a committee is appointed, the commissioner shall: (1) consider the interest of all stakeholders when selecting committee members; (2) select members that represent both urban and rural interests; and (3) select members that include ambulatory care as well as inpatient perspectives. The commissioner shall appoint to the advisory committee representatives of the following groups: medical researchers, public and private academic medical centers, managed care organizations, Blue Cross Blue Shield of Minnesota, commercial carriers, Minnesota Medical Association, Minnesota Nurses Association, medical product manufacturers, employers and other relevant stakeholders, including consumers. The advisory committee is governed by section 15.059, for membership terms and removal of members and will sunset on June 30, 1999.

(c) Eligible applicants for funds are accredited medical education teaching institutions, consortia, and programs operating in Minnesota. Applications must be submitted by the sponsoring institution on behalf of the teaching program, and must be received by September 30 of each year for distribution in January of the following year. An application for funds must include the following:

(1) the official name and address of the sponsoring institution and the official name and address of the facility or program on whose behalf the institution is applying for funding;

(2) the name, title, and business address of those persons responsible for administering the funds;

(3) the total number, type, and specialty orientation of eligible Minnesota-based trainees in each accredited medical education program for which funds are being sought;

(4) audited clinical training costs per trainee for each medical education program;

(5) a description of current sources of funding for medical education costs including a description and dollar amount of all state and federal financial support;

(6) other revenue received for the purposes of clinical training;

(7) a statement identifying unfunded costs; and

Appendix 3

(8) other supporting information the commissioner, with advice form the advisory committee, determines is necessary for the equitable distribution of funds.

(d) The commissioner shall distribute medical education funds to all qualifying applicants based on the following basic criteria: (1) total medical education funds available; (2) total eligible trainees in each eligible education program; and (3) the statewide average cost per trainee, by type of trainee, in each medical education program. Funds distributed shall not be used to displace current funding appropriations from federal or state sources. Funds shall be distributed to the sponsoring institutions indicating the amount to be paid to each of the sponsor's medical education programs based on the criteria in this paragraph. Sponsoring institutions which receive funds from the trust fund must distribute approved funds to the medical education program according to the commissioner's approval letter. Further, programs must distribute funds among the sites of training based on the percentage of total program training performed at each site.

(e) Medical education programs receiving funds from the trust fund must submit annual cost and program reports through the sponsoring institution based on criteria established by the commissioner. The reports must include:

(1) the total number of eligible trainees in the program;

(2) the programs and residencies funded, the amounts of trust fund payments to each program, and within each program, the percentage distributed to each training site;

(3) the average cost per trainee and a detailed breakdown of the components of those costs;

(4) other state or federal appropriations received for the purposes of clinical training;

(5) other revenue received for the purposes of clinical training; and

(6) other information the commissioner, with the advice form the advisory committee, deems appropriate to evaluate the effectiveness of the use of funds for clinical training.

The commissioner, with advice from the advisory committee, will provide an annual summary report to the legislature on program implementation due February 15 of each year.

(f) The commissioner is authorized to distribute funds made available through:

(1) voluntary contributions by employers or other entities;

(2) allocations for the department of human services to support medical education and research; and

(3) other sources as identified and deemed appropriate by the legislature for inclusion in the trust fund.

(g) The advisory committee shall continue to study and make recommendations on:

(1) the funding of medical research consistent with work currently mandated by the legislature and under way at the department of health; and

(2) the costs and benefits associated with medical education and research.

Subd. 3. **Medical assistance and general assistance service.** The commissioner of health, in consultation with the medical education and research costs advisory committee, shall develop a system to recognize those teaching programs which serve higher numbers or high proportions of public program recipients and shall report to the legislative commission on health care access by January 15, 1998, on an allocation formula to implement this system.

1997 Minnesota Laws Chapter 225, Article 7, Section 2

Subdivision 1. **Medical Education.** Of the fiscal year 1998 health care access fund appropriation, $3,500,000 is for medical education research costs. This appropriation, plus the federal financial participation amount shall be distributed to medical assistance providers according to the distribution

methodology of the medical education research trust fund established under Minnesota Statutes, section 62J.69. Any unspent funds in this appropriation do not cancel but may carry forward and be available in fiscal year 1999.

1997 Minnesota Laws Chapter 203, Article 1, Section 2, Subd. 5

Subd. 5. **Distribution to Medical Assistance Providers.** (a) Of the amount appropriated to the medical assistance account in fiscal year 1998, $5,000,000 plus the federal financial participation amount shall be distributed to medical assistance providers according to the distribution methodology of the medical education research trust fund established under Minnesota Statute 62J.69.

(b) In fiscal year 1999, the prepaid medical assistance and prepaid general assistance medical care capitation rate reduction amounts under Minnesota Statutes, section 256B.69, subdivision 5c, and the federal financial participation amount associated with the medical assistance reduction, shall be distributed to medical assistance providers according to the distribution methodology of the trust fund.

Minnesota Statute 256B.69 Prepayment Demonstration Project

Subd. 5c. **Medical education and research trust fund.** (a) Beginning in January 1999 and each year thereafter:

(1) the commissioner of human services shall transfer an amount equal to the reduction in the prepaid medical assistance and prepaid general assistance medical care payments resulting from clause (2), excluding nursing facility and elderly waiver payments, to the medical education and research trust fund established under section 62J.69;

(2) the county medical assistance and general assistance medical care capitation base rate prior to plan specific adjustments shall be reduced 6.3 percent for Hennepin county, two percent for the remaining metropolitan counties, and 1.6 percent for nonmetropolitan Minnesota counties; and

(3) the amount calculated under clause (1) shall not be adjusted for subsequent changes to the capitation payments for periods already paid.

(b) This subdivision shall be effective upon approval of a federal waiver which allows federal financial participation in the medical education and research trust fund.

1997 Minnesota Laws Chapter 203, Article 2, Section 31

Sec. 31. **Funding sources for the medical education and research trust fund.** (a) The commissioner of health, in consultation with the medical education research costs advisory committee, shall continue to consider additional broad-based funding sources, and shall recommend potential sources of funding to the legislature by February 15, 1998.

(b) The commissioner of health, in consultation with the commissioner of human services, shall examine the appropriateness of transferring an educational component from the MinnesotaCare rates to the medical education and research trust fund, and the appropriate amount and timing of any such transfer. The commissioner shall report recommendations on the feasibility of including MinnesotaCare funding in the trust fund to the legislature by February 15, 1998.

Appendix 4

1998 MERC Statute and Uncodified Session Laws

Minnesota Statute Section 62J.69: Medical Education and Research Trust Fund

Subd. 1 **Definitions.** For purposes of this section, the following definitions apply:

(a) "Medical education" means the accredited clinical training of physicians (medical students and residents), doctor of pharmacy practitioners, doctors of chiropractic, dentists, advanced practice nurses (clinical nurse specialist, certified registered nurse anesthetists, nurse practitioners, and certified nurse midwives), and physician assistants.

(b) "Clinical training" means accredited training for the health care practitioners listed in paragraph (a) that is funded in part by patient care revenues and that occurs in either an inpatient or ambulatory patient care training site.

(c) "Trainee" means students involved in an accredited clinical training program for medical education as defined in paragraph (a).

(d) "Eligible trainee" means a student involved in an accredited training program for medical education as defined in paragraph (a), which meets the definition of clinical training in paragraph (b), who is in a training site that is located in Minnesota and which has a medical assistance provider number.

(e) "Health care research" means approved clinical, outcomes, and health services investigations that are funded by patient out-of-pocket expenses or a third-party payer.

(f) "Commissioner" means the commissioner of health.

(g) "Teaching institutions" means any hospital, medical center, clinic, or other organization that currently sponsors or conducts accredited medical education programs or clinical research in Minnesota.

(h) "Accredited training" means training provided by a program that is accredited through an organization recognized by the Department of Education or the Health Care Financing Administration as the official accrediting body for that program.

(i) "Sponsoring institution" means a hospital, school, or consortium located in Minnesota that sponsors and maintains primary organizational and financial responsibility for an accredited medical education program in Minnesota and which is accountable to the accrediting body.

Subd. 2. **Allocation and funding for medical education and research.**

(a) The commissioner may establish a trust fund for the purposes of funding medical education and research activities in the state of Minnesota.

(b) By January 1, 1997, the commissioner may appoint an advisory committee to provide advice and oversight on the distribution of funds from the Medical Education and Research Costs Trust Fund. If a committee is appointed, the commissioner shall:

(1) consider the interest of all stakeholders when selecting committee members;

(2) select members that represent both urban and rural interest; and

(3) select members that include ambulatory care as well as inpatient perspectives. The commissioner shall appoint to the advisory committee representatives of the following groups: medical researchers, public and private academic medical centers, managed care organizations, Blue Cross and Blue Shield of Minnesota, commercial carriers, Minnesota Medical Association, Minnesota Nurses Association, medical product manufacturers, employers, and other relevant stakeholders, including consumers. The advisory committee is governed by section 15.059, for membership terms and removal of members and will sunset on June 30, 1999.

(c) Eligible applicants for funds are accredited medical education teaching institutions, consortia, and programs operating in Minnesota. Applications must be submitted by the sponsoring institution on ·

behalf of the teaching program, and must be received by September 30 of each year for distribution in January of the following year. An application for funds must include the following:

(1) the official name and address of the sponsoring institution and the official name and address of the facility or programs on whose behalf the institution is applying for funding;

(2) the name, title, and business address of those persons responsible for administering the funds;

(3) for each accredited medical education program for which funds are being sought the type and specialty orientation of trainees in the program, the name, address, and medical assistance provider number of each training site used in the program, the total number of trainees at each site, and the total number of eligible trainees at each training site;

(4) audited clinical training costs per trainee for each medical education program where available or estimates of clinical training costs based on audited financial data;

(5) a description of current sources of funding for medical education costs including a description and dollar amount of all state and federal financial support, including Medicare direct and indirect payments;

(6) other revenue received for the purposes of clinical training; and

(7) other supporting information the commissioner, with advice from the advisory committee, determines is necessary for the equitable distribution of funds.

(d) The commissioner shall distribute medical education funds to all qualifying applicants based on the following basic criteria: (1) total medical education funds available; (2) total eligible trainees in each eligible education program; and (3) the statewide average cost per trainee, by type of trainee, in each medical education program. Funds distributed shall not be used to displace current funding appropriations from federal or state sources. Funds shall be distributed to the sponsoring institutions indicating the amount to be paid to each of the sponsor's medical education programs based on the criteria in this paragraph. Sponsoring institutions which receive funds from the trust fund must distribute approved funds to the medical education program according to the commissioner's approval letter. Further, programs must distribute funds among the sites of training as specified in the commissioner's approval letter. Any funds not distributed as directed by the commissioner's approval letter shall be returned to the medical education and research trust fund within 30 days of a notice from the commissioner. The commissioner shall distribute returned funds to the appropriate entities in accordance with the commissioner's approval letter.

(e) Medical education programs receiving funds from the trust fund must submit a medical education and research grant verification report (GVR) through the sponsoring institution based on criteria established by the commissioner. If the sponsoring institution fails to submit the GVR by the stated deadline, or to request and meet the deadline for an extension, the sponsoring institution is required to return the full amount of the medical education and research trust fund grant to the medical education and research trust fund within 30 days of a notice from the commissioner. The commissioner shall distribute returned funds to the appropriate entities in accordance with the commissioner's approval letter. The reports must include:

(1) the total number of eligible trainees in the program;

(2) the programs and residencies funded, the amounts of trust fund payments to each program, and within each program, the dollar amount distributed to each training site; and

(3) other information the commissioner, with advice from the advisory committee, deems appropriate to evaluate the effectiveness of the use of funds for clinical training.

The commissioner, with advice from the advisory committee, will provide an annual summary report to the legislature on program implementation due February 15 of each year.

(f) The commissioner is authorized to distribute funds made available through:

(1) voluntary contributions by employers or other entities;

(2) allocations for the department of human services to support medical education and research; and

(3) other sources as identified and deemed appropriate by the legislature for inclusion in the trust fund.

(g) The advisory committee shall continue to study and make recommendations on:

(1) the funding of medical research consistent with work currently mandated by the legislature and under way at the department of health; and

(2) the costs and benefits associated with medical education and research.

Subd. 3. **Medical assistance and general assistanceservice.** The commissioner of health, in consultation with the medical education and research costs advisory committee, shall develop a system to recognize those teaching programs which serve higher numbers or high proportions of public program recipients and shall report to the legislative commission on health care access by January 15, 1998, on an allocation formula to implement this system.

Subd. 4. **Transfers from the commissioner of human services** (a) The amount transferred according to section 256B.69, subdivision 5c, shall be distributed to qualifying applicants based on a distribution formula that reflects a summation of two factors:

(1) an education factor, which is determined by the total number of eligible trainees and the total statewide average costs per trainee, by type of trainee, in each program; and

(2) a public program volume factor, which is determined by the total volume of public program revenue received by each training site as a percentage of all public program revenue received by all training sites in the trust fund pool. In this formula, the education factor shall be weighted at 50 percent and the public program volume factor shall be weighted at 50 percent.

(b) Public program revenue for the formula in paragraph (a) shall include revenue from medical assistance, prepaid medical assistance, general assistance medical care, and prepaid general assistance medical care.

(c) Training sites that receive no public program revenue shall be ineligible for payments from the prepaid medical assistance program transfer pool.

Subd. 5. **Review of eligible providers** (a) Provider groups added after January 1, 1998, to the list of providers eligible for the trust fund shall not receive funding from the trust fund without prior evaluation by the commissioner and the medical education and research costs advisory committee. The evaluation shall consider the degree to which the training of the provider group:

(1) takes place in patient care settings, which are consistent with the purposes of this section;

(2) is funded with patient care revenues;

(3) takes place in patient care settings, which face increased financial pressure as a result of competition with nonteaching patient care entities; and

(4) emphasizes primary care or specialties, which are in undersupply in Minnesota.

Results of this evaluation shall be reported to the legislative commission on health care access. The legislative commission on health care access must approve funding for the provider group prior to their receiving any funding from the trust fund. In the event that a reviewed provider group is not approved by the legislative commission on health care access, trainees in that provider group shall be considered ineligible trainees for the trust fund distribution.

(b) The commissioner and the medical education and research costs advisory committee may also review provider groups, which were added to the eligible list of provider groups prior to January 1, 1998, to assure that the trust fund money continues to be distributed consistent with the purpose of this section. The results of any such reviews must be reported to the legislative commission on health care access. Trainees in provider groups, which were added prior to January 1, 1998, and which are reviewed by the commissioner and the medical education and research costs advisory committee, shall be considered eligible trainees for purposes of the trust fund distribution unless and until the legislative commission on health care access disapproves their eligibility, in which case they shall be considered ineligible trainees.

Appendix 4

1998 Minnesota Laws Chapter 407, Article 2, Section 98

Sec. 98. Report by the University of Minnesota Academic Health Center. The University of Minnesota academic health center, after consultation with the health care community and the medical education and research costs advisory committee, is requested to report to the commissioner of health and the legislative commission on health care access by January 15, 1999, on plans for the strategic direction and vision of the academic health center. The report shall address plans for the ongoing assessment of health provider workforce needs; plans for the ongoing assessment of the educational needs of health professionals and the implications for their education and training programs; and plans for ongoing, meaningful input from the health care community on health-related research and educational programs administered by the academic health center.

1998 Minnesota Laws Chapter 407, Article 2, Section 106

Sec. 106. Medical Education and Research Trust Fund Study The commissioner of health shall review the current medical education and research costs advisory committee structure and composition and recommend methods to ensure balanced and appropriate representation of major training programs. The commissioner shall also review the statutory formula for the prepaid medical assistance carve out to determine if any adjustments should be made to correct existing or potential inequities on current training programs. The commissioner shall determine if there should be other criteria for weighting future distributions of medical education and research funds beyond the current statutory criteria, including the criteria that trainees continue to practice in Minnesota. The commissioner shall report the findings and recommendations to the legislative commission on health care access by December 15, 1998.

Appendix 5

HISTORICAL REPORTS ON MEDICAL EDUCATION AND RESEARCH COSTS

1. *Future Funding for Medical Education and Research in Minnesota. A report to the Legislature and Recommendations for continued Study. March 1994.*

2. *Medical Education and Research Costs (MERC) In Minnesota's Reformed Health Care System. An interim Report from the Commissioner of Health to the legislature. March 1995.*

3. *Medical Education and Research Costs (MERC). A final Report to the Legislature. February 1996.*

4. *Medical Education and Research Costs (MERC). Study Recommendations and Progress Report to the Legislature. December 1996.*

5. *Estimating the Cost of Medical Education: Issues and Dilemmas. February 24, 1997.*

6. *Medical Education and Research Costs (MERC). Recommendations on Distribution of PMAP/PGAMC Funds. A report to the Minnesota Legislature. February 1998*

7. *Medical Education and Research Costs (MERC). Annual Report on Program Implementation and Recommendations. April 1998.*

Copies of the above listed publications can be requested from:

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Appendix 6

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